(10)

No. 90-97

In the Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
PETITIONER

v.

NATIONAL LABOR RELATIONS BOARD, ET AL.,
RESPONDENTS

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF AMICUS CURIAE OF WILLIAM BEAUMONT HOSPITAL, HENRY FORD HOSPITAL, ST. JOHN HOSPITAL AND MEDICAL CENTER, AND THE MICHIGAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITIONER

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William Beaumont Hospital, Henry Ford Hospital, St. John Hospital and Medical Center, and the Michigan Hospital Association respectfully submit this *amicus curiae* brief in support of the American Hospital Association's petition for a writ of certiorari.[1]

INTEREST OF THE AMICI CURIAE

The three individual hospitals submitting this *amicus curiae* brief — William Beaumont Hospital, Henry Ford Hospital, and St. John Hospital and Medical Center — are among the largest and most diversified acute care hospitals in the state of Michigan.

[1] The written consent of each of the parties to the filing of this brief has been filed with the Court.

Located in metropolitan Detroit, these three hospitals account for nearly 20 percent of all hospital admissions in southeastern Michigan. They collectively employ nearly 20,000 individuals at their primary hospital locations and at numerous medical centers and satellite facilities throughout the Detroit metropolitan area. With only the remotest of exception (largely involving guards), the workforces of these hospitals have not been organized by labor unions.

The fourth *amicus curiae*, the Michigan Hospital Association, is a voluntary non-profit membership corporation consisting of 209 organizations that provide critical health care services to the 9,000,000 citizens of Michigan. Member facilities range in size from the 15-bed 379th Strategic Hospital at the Wurtsmith Air Force Base to the 960-bed Henry Ford Hospital in downtown Detroit. Approximately one-half of the Association's members are small institutions having fewer than 100 beds; most of these are located in rural areas of Michigan where they serve as the primary providers of health care services in their communities. The other half of the Association's members serve the various urban areas of the state.

The three individual hospitals submitting this *amicus* brief, and a substantial number of the Association's other members, are deeply affected by the National Labor Relations Board's promulgation through rulemaking of a virtually *conclusive presumption* that eight collective bargaining units are appropriate for them and for all other acute care hospitals throughout the United States. The Board's rule is predicated on a fundamentally mistaken "empirical" premise: that all acute care hospitals are the same, as if fashioned from a single cookie cutter, regardless of their substantial differences in mission, location, size, organizational structure, staffing patterns, and the like. The Board's rule purports to treat all hospitals according to a least-common-denominator model without any pretense of giving consideration to the unique characteristics of each hospital — uniquenesses that are illustrated by the hospitals and Association members submitting this brief.

In view of the immense and disruptive potential for case-by-case litigation over the validity of the Board's rule, in Michigan and elsewhere, *amici curiae* respectfully urge that the Court grant the American Hospital Association's petition for a writ of certiorari, and declare that the Board's rule universally prescribing eight separate units for every acute care hospital was improperly promulgated and cannot be applied.

INTRODUCTION AND SUMMARY OF ARGUMENT

At first blush the Board's rule prescribing eight units for all acute care hospitals may appear to be an efficient and sensible way of creating predictability and minimizing litigation in this important field. It becomes clear upon closer scrutiny, however, that the Board's rule has severe defects warranting this Court's review now.

Perhaps most remarkably, the Board's rule flies in the face of the National Labor Relations Act's own language, which in Section 9(b) requires that bargaining unit determinations be made "in each case." The explanations given by the Board for effectively erasing this language from the Act do not survive analysis. The Act clearly requires the Board to conduct case-by-case adjudications to determine appropriate bargaining units in this and every other industry — thereby taking into account the unique characteristics of particular employers and their employee groupings.

The Board's rule also disregards the congressional admonition against proliferation of bargaining units in the health care industry. While the Board suggests that the eight units prescribed for acute care hospitals in the rule is not *that many* more than the three-unit statutory minimum, or the six-unit configuration the Board proposed at the outset of its rulemaking proceeding, the addition of even one or two more bargaining units — *and these are the units likely to become organized* — causes undue proliferation and the potential for all of the disruptive consequences feared by Congress when the Act was amended in 1974. The

Board is seeking to accomplish through rulemaking the very same result that the courts have repeatedly struck down in adjudicated cases as violative of the congressional admonition. This warrants review by this Court.

The Board's rule is also arbitrary and capricious. It presumes that alleged "empirical" evidence *generally* applicable to the hospital industry may legally surmount *particularized* evidence concerning the structure and operations of a specific hospital. As the Board's own prior adjudicatory decisions show, there are wide variations within this rapidly evolving industry that require flexibility in unit determinations. The rule conclusively prohibits this flexibility.

Underlying the Board's rulemaking is its unwarranted belief that Congress was simply wrong when it expressed concern in 1974 over work stoppages, jurisdictional disputes, whipsawing, and leapfrogging in the health care industry. Those were then, and are still, real and legitimate concerns for individual hospitals and for the industry as a whole. The Board has effectively overruled Congress' concern. The American Hospital Association's petition should be granted.

ARGUMENT

I. Section 9(b)'s "In Each Case" Requirement Mandates Individual Bargaining Unit Determinations

In its First and Second Notices of Proposed Rulemaking, and in promulgating its Final Rule, the Board considered but rejected the argument raised by commentators that it is improper for the Board affirmatively to prescribe *substantive bargaining units* for a class of employers through rulemaking. NPR I, 52 Fed.Reg. 25144-25145; NPR II, 53 Fed.Reg. 33901; Final Rule, 54 Fed.Reg. 16338. The Board acknowledged that this is the Board's "first venture in major, substantive rulemaking," *id.* at 16339, inasmuch as its prior rulemaking had involved non-substantive procedural or jurisdictional matters applicable to cases generally.

One Board Member, Wilford W. Johansen, dissented from the Board majority's conclusion that Section 9(b)'s "in each case" requirement permits this type of substantive bargaining unit rulemaking. NPR II, 53 Fed.Reg. 33935; 54 Fed.Reg. 16347. Eight years earlier, a differently composed Board had adopted what has now apparently become the dissenting view. In *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980), the Board held that the "in each case" requirement of Section 9(b) precluded any *per se* approach to unit determinations. Two years later, in *St. Francis Hospital I*, 265 NLRB 1025, 1028 (1982), the Board reaffirmed the view that Section 9(b)'s "in each case" requirement mandated case-by-case adjudication; and it did so again in *St. Francis Hospital II*, 271 NLRB 948, 954 (1984) ("[N]o unit is *per se* appropriate and . . . separate representation must be justified upon each factual record . . .").

What rational explanation has the Board presented for its abruptly changed view of the Act's "in each case" requirement? The Board has essentially stated three reasons, but none withstands scrutiny.

First, the Board majority has extensively relied on language from Kenneth Culp Davis' *Administrative Law Text* 145 (3d ed. 1972) that Section 9(b)'s "in each case" requirement

> does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding "in each case" are classifications, rules, principles, and precedents.

NPR I, 52 Fed.Reg. 25144; NPR II, 53 Fed.Reg. 33901; see also Final Rule, 54 Fed.Reg. 16338.[2] Beyond that, the Board majority notes that "[i]t has long been the Board's practice to formulate 'rules' to guide it in representation matters," including contract

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[2] Davis' *Administrative Law Text* is a law student hornbook. *Id.* at III. The quoted comment concerning the Act's "in each case" requirement does not appear in Davis' subsequent treatises, which more broadly discuss the Board's rulemaking power. See, e.g., 2 Davis, *Administrative Law Treatise* §7:25 (1979).

bar rules, voter eligibility list requirements, and the like. NPR II, 53 Fed.Reg. 33901.

The shortcoming in the Board majority's reasoning is that Davis' comment was not referring to *substantive rules affirmatively prescribing universally appropriate bargaining units for an entire industry*. Davis was referring instead to "classifying problems, ... developing rules or principles, ... or relying on precedent cases which establish narrow or broad propositions." *Administrative Law Text, supra*. What the Board has now done is a far cry from establishing those types of general rules (exemplified by the contract bar rule and voting eligibility list requirement), which merely define the perimeters within which representation questions will be determined. It is a remarkable stretch of logic to suggest, as the Board majority does, that Davis' comment or the Board's own prior rulemaking can legitimize the instant rule. The dissenting Board member properly rejected this justification.

The Board secondly contends that this Court's decision in *Heckler* v. *Campbell*, 461 U.S. 458 (1983), a case addressing the Social Security Administration's "grid" method of determining disability benefit entitlements, supports the Board's substantive unit determinations for the hospital industry. But *Heckler* provides no support at all, and indeed counsels the contrary. This Court there held that an "agency may rely on its rulemaking authority to determine issues that do *not* require case-by-case consideration." *Id.* at 467 (emphasis added). Here the Board is obligated by Section 9(b) of the Act to make a unit determination "in each case." What is more, *Heckler* held that the Secretary was required to make "findings on the basis of evidence adduced at a hearing" with regard to a claimant's individual abilities and qualifications, and that the Secretary could utilize rulemaking *only* for determining "an issue that is not unique to each claimant." *Id.* at 467-468. It is this portion of the *Heckler* decision that applies here.

There may be historical or statistical information regarding hospitals — analogous to the national employment and economic

information in *Heckler* — that the Board could properly assimilate into a representation case's hearing record through rulemaking. But the existence *vel non* of distinct and appropriate bargaining units in a particular hospital is unquestionably an issue that is "unique" to that hospital.

Third, the Board asserts that, notwithstanding its eight-unit rule, an acute care hospital will always be permitted a hearing in a representation case and that a hospital can in any event take advantage of the "extraordinary circumstances" exception if its own unique characteristics do not fit the mold of the rule. Final Rule, 54 Fed.Reg. 16338 and n.2. These offerings by the Board ring hollow. If the Board was serious about this, it would have crafted a rule containing *rebuttable*, rather than virtually *irrebuttable*, presumptions of appropriate units; the Board rejected that option as unnecessary and inefficient. NPR I, 52 Fed.Reg. 25145; Final Rule, 54 Fed.Reg. 16338-16339. It could not be clearer that the Board does not want individualized hearings on hospital bargaining units. Only evidence concerning ancillary issues — not related to appropriate units — would be allowed in a representation hearing. Final Rule, 54 Fed.Reg. 16338. And the "extraordinary circumstances" exception has been repeatedly described by the Board as so narrow as to banish it from existence. NPR I, 52 Fed.Reg. 25145; NPR II, 53 Fed.Reg. 33932. The Board's catalog of factual "variations in acute care hospitals" that will *not* be considered under the "extraordinary circumstances" exception *(id.)* is so comprehensive as to render it meaningless. That exception surely cannot be held out by the Board as a cure-all for the rule's denial of due process and its disregard of Section 9(b)'s "in each case" requirement.

There can be no doubt that the purpose and effect of the Board's rule mandating eight bargaining units in all acute care hospitals is to eliminate, once and for all, unit determinations "in each case." That result not only runs afoul of Section 9(b), but is

at odds with decisions of this Court.[3] The Seventh Circuit's decision upholding the Board's rule is also in conflict with decisions of other Courts of Appeals that have previously found *per se* approaches by the Board to unit determinations violative of Section 9(b)'s "in each case" requirement.[4]

II. The Board's Rule Is Precluded By The Congressional Admonition Against Proliferation Of Bargaining Units In The Health Care Industry

Much debate has focused over the past 15 years on the weight and meaning to be ascribed to the admonition contained in the House and Senate Reports to the Health Care Amendments Act of 1974 that the Board give "[d]ue consideration ... to preventing proliferation of bargaining units in the health care industry." S.Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R.Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). The Seventh Circuit's decision below, holding the congressional admonition entitled only to "respectful consideration," is squarely in conflict with decisions of other Courts of Appeals which have given the admonition controlling weight in rejecting Board unit determinations.[5] This conflict warrants a grant of certiorari in this case.

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[3] See *Packard Motor Car Co.* v. *NLRB*, 330 U.S. 485, 491 (1947); *NLRB* v. *Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944).

[4] See, e.g., *Big Y Foods, Inc.* v. *NLRB*, 651 F.2d 40, 45-46 (1st Cir. 1981); *Long Island College Hospital* v. *NLRB*, 566 F.2d 833, 840-841 (2d Cir. 1977), *cert. denied*, 435 U.S. 896 (1978); *Trustees of the Masonic Hall & Asylum Fund* v. *NLRB*, 699 F.2d 626, 638 (2d Cir. 1983); *Memorial Hospital of Roxborough* v. *NLRB*, 545 F.2d 351, 360 (3d Cir. 1976); *Allegheny General Hospital* v. *NLRB*, 608 F.2d 965, 968 (3d Cir. 1979); *NLRB* v. *St. Francis Hospital of Lynwood*, 601 F.2d 404, 416 (9th Cir. 1979).

[5] See *Trustees of the Masonic Hall & Asylum Fund* v. *NLRB*, *supra*, 699 F.2d 626, 638 (2d Cir. 1983); *NLRB* v. *St. Francis Hospital of Lynwood*, 601 F.2d 404, 416 (9th Cir. 1979); *Presbyterian/St. Luke's Medical Center* v. *NLRB*, 653 F.2d 450, 457 (10th Cir. 1981). At the opposite end of the spectrum from these decisions is the D.C. Circuit's decision in *International Brotherhood of Electrical Workers* v. *NLRB*, 814 F.2d 697, 712 (D.C. Cir. 1987), which found the congressional admonition essentially meaningless because it was never incorporated into the Act itself.

When the Board initially undertook hospital unit determinations after the 1974 amendments, it generally found eight units appropriate — just as the present rule does. This formulation met with little success in the Courts of Appeals,[6] primarily for the reason that those units failed to comport with the congressional admonition. The Board then reconsidered its overall approach to hospital units. In *St. Francis Hospital II*, 271 NLRB 948 (1984), the Board formulated a new standard, moving from a "community of interests" test that generally produced eight appropriate units in a hospital to a "disparity of interests" test that generally produced five units, stating:

> With the benefit of many years of thoughtful and often conflicting analyses among the Board members, courts of appeals, and legal commentators, we have formulated a revised health care employee unit approach which we believe will fulfill our dual obligations of adhering to the legislative intent behind enactment of the 1974 health care amendments to the Act and guaranteeing the representational interests of health care employees.
>
> 271 NLRB at 948 (footnote omitted).

"After careful and thorough consideration," the Board continued in *St. Francis II*, its Members were "persuaded" that the prior approach was "contrary to the intent of Congress" and that "the adoption of a disparity-of-interests tests can best effectuate our statutory obligations in health care unit determinations." *Id.* at 950. Furthermore, "Congress clearly intended that, in determining appropriate units in the health care area, the Board should apply a stricter standard than its traditional community-of-interest analysis." *Id.* at 951.

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[6] See, e.g., *Mary Thompson Hospital* v. *NLRB*, 621 F.2d 858 (7th Cir. 1980); *NLRB* v. *Mercy Hospital Association*, 606 F.2d 22 (2d Cir. 1979), *cert. denied*, 445 U.S. 971 (1980); *NLRB* v. *West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978).

The eight-unit formulation found in the Board's rule today is no different than the eight-unit formulation (utilized prior to *St. Francis II*) which had been rejected by many Courts of Appeals as inconsistent with the congressional admonition. The only notable difference is that the Board's new rule purports to be based on "empirical" evidence regarding the health care industry as a whole, rather than on an evidentiary record compiled in a single adjudicatory proceeding; in addition, the rule purports to govern an entire industry rather than a single hospital.

Thus, there is no dispute that the Board is attempting to accomplish through "empirical" rulemaking exactly what the courts have forbidden as violative of the congressional admonition — an eight-unit configuration for hospitals. Anomalously, the Board has taken this across-the-board approach in the *only* industry for which Congress expressed concern that the Board act with special care in determining units. No other class of employers has been singled out by the Board for the mandatory establishment of bargaining units without any regard to the configuration of their particular operations.[7]

In summary, in conjunction with Section 9(b)'s "in each case" requirement, the congressional admonition mandates that the Board conduct case-by-case adjudications to determine appropriate bargaining units in the health care industry — no less than it does in all other industries — and in so doing to avoid unit proliferation at each hospital. The Board's rule is the very

[7] The Board has repeatedly emphasized throughout the rulemaking proceedings that, even though its rule provides for eight separate bargaining units, it is unusual that a hospital would actually be organized to this extent by labor unions. NPR II, 53 Fed.Reg. 33908, 33909, 33910, 33923, 33933, 33934; Final Rule, 54 Fed.Reg. 16346. This misses the relevant point, however, because the Board's rule makes it an inevitability that there would be eight separate units in the event unions sought to organize them. And the advance subdividing of the work force would facilitate such organizing. It is thus illogical for the Board to suggest that the *presently* incomplete state of union organization mitigates the violence its rule does to the congressional admonition against proliferation.

Ironically, the Board states in NPR II that proliferation is relieved by the fact that guard units are "rarely sought" (53 Fed.Reg. 33934). It is precisely those units that have been organized at the three hospitals submitting this brief.

antithesis of this mandate, because it prescribes that every acute care hospital will have eight bargaining units.[8] The Seventh Circuit's decision upholding the Board's rule notwithstanding the congressional admonition merits review by this Court.

III. The Board's Rule Is Arbitrary And Capricious

The Board has acknowledged that it engaged in this rulemaking because the courts rejected its prior approach to health care bargaining units:

> Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974.
>
> NPR I, 52 Fed.Reg. 25143.[9]

[8] The Board itself increased the number of mandatory units at acute care hospitals from six in NPR I (52 Fed.Reg. 25149) to eight in NPR II (53 Fed.Reg. 33934), conclusorily stating in NPR II that the addition of these two units (skilled maintenance and business office clericals) did not produce a proliferation of bargaining units (53 Fed.Reg. 33923, 33926). The Board noted that 23 conceivable bargaining units (and perhaps an equal number of additional units) could *theoretically* arise in any single establishment, and that it is in any event "unlikely that all eight potential appropriate units will occur in any given hospital" (54 Fed.Reg. 16346). Needless to say, these statistics and predictions are of no solace to hospitals for whom the proliferation of even one or two additional units can have major consequence.

[9] The Board initiated the rulemaking process in apparent reaction to the D.C. Circuit's decision in *International Brotherhood of Electrical Workers* v. *NLRB*, 814 F.2d 697 (D.C. 1987), holding (as no other Circuit had) that the Board had *improperly* concluded that the congressional admonition mandated a "disparity of interests" test for hospital bargaining units. The D.C. Circuit also held, however, that the Board possessed discretion to adopt a "disparity of interests" test, and expressed no view as to what test the Board should embrace in the exercise of its discretion. *Id.* at 699, 708 n.37, 711-712 n.65. See also *St. Vincent Hospital*, 285 NLRB 365, 367 (1987). Nothing precluded the Board from continuing to adhere to the "disparity of interests" test notwithstanding the D.C. Circuit's decision in *IBEW* v. *NLRB*, as the Board chose to do in *St. Vincent Hospital*.

But why should a result achieved through rulemaking suceed where the identical result achieved through adjudication failed? The Board's rule rests on the notion that "empirical" evidence concerning the hospital industry *generally* can legitimize a result (eight *per se* appropriate units) that has been and would be struck down in an adjudicatory proceeding.

The fundamental problem with the Board's approach is highlighted by this Court's decision in *Heckler* v. *Campbell*, *supra*. Just as individual Social Security disability claimants' qualifications required individual hearings as to their unique facts in *Heckler*, acute care hospitals are also sufficiently unique in mission, location, size, organizational structure, staffing patterns, and the like, to require individualized hearings concerning appropriate bargaining units. Individual hospitals are not fungible, nor are they mere statistics. It is wrong for the Board to declare by rule or fiat that they are.

This error pervades NPR II. It repeatedly acknowledges that the Board has based its rule on generalized least-common-denominator evidence and has purposefully eschewed deviations from the general pattern at particular hospitals. A single but dramatic example concerns the use by some hospitals of special multi-disciplinary teams. The Board emphasizes that "the *weight* of the evidence shows that utilization of team care is neither widespread among hospitals, nor extensively used within hospitals," and that "*fewer than half*" of the hospitals studied used special multi-disciplinary teams while "*[s]ome* hospitals do not utilize the team concept at all." NPR II, 53 Fed.Reg. 33907 (emphasis added). What the Board overlooks is that many hospitals do use special multi-disciplinary teams, in a fashion that removes them from the mainstream and warrants consideration of a different bargaining unit structure. There are many other examples in NPR II of individual variations being dismissed by the Board in favor of the "typical," "normal," or "general"

characteristics of hospitals. It is nevertheless indisputable that some hospitals do not fit that mold.[10]

The arbitrariness of the Board's rule can also be seen in its treatment of *its own prior decisions* holding inappropriate, on the unique facts presented in those adjudications, the very bargaining units its rule would today declare universally appropriate. In *St. Vincent Hospital*, 285 NLRB 365 (1987), the Board held on the basis of an adjudicatory record that a separate registered nurses unit was inappropriate at that hospital because of the hospital's particular organizational structure, personnel policies, integration of employees, and the like. The Board's rule now decrees that a separate registered nurses unit is universally appropriate. The Board has sought to harmonize this inconsistency as follows:

> Having now had the opportunity to consider the substantial empirical evidence adduced in this rulemaking proceeding, we have a far better understanding of the RNs' training, functions, interests, and involvement in hospital operations. . . . [W]ere we to apply the empirical evidence presented in these hearings, we might well reach a different result in *St. Vincent*.
>
> NPR II, 53 Fed.Reg. 33916.

The Board has used the same sleight-of-hand for a separate skilled maintenance unit, which the Board had held inappropriate on the factual record in *St. Francis Hospital III*, 286 NLRB 1305 (1987), see NPR II, 53 Fed.Reg. 33923; and a separate business office clerical unit, which it had held inappropriate on the factual record in *Baker Hospital*, 279 NLRB 308 (1986), see NPR II, 52 Fed.Reg. 33926. Regardless of a particular hospital's configuration of these employee groupings, skilled maintenance and business office clerical units are now declared universally appropriate.

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[10] That the Board will permit non-conforming stipulations (NPR II, 53 Fed.Reg. 33931) also demonstrates that some hospitals are sufficiently far from the "normal" or "typical" configuration as to warrant different treatment.

The rule's arbitrariness is further shown by its failure to allow for full evidentiary consideration of the unique characteristics of large and diversified acute care hospitals (such as those submitting this *amicus* brief) and the ramifications of those characteristics on unit determinations. Many large urban hospitals today operate through an integrated network of dispersed medical centers and other facilities that comprise a single hospital system. Indeed, some have several geographically separate "campuses," but may well share employees, administrative services, and patients. Depending on a particular hospital system's organization, various locations may, or may not, have employees with identical interests, working conditions, supervision, and the like. It would be arbitrary indeed for a rule to presume irrebuttably (as the Board's rule evidently does) that such an organizational and geographic structure must be disregarded, and that only contiguous facilities be considered, in assigning the eight bargaining units decreed by the rule. See NPR II, 53 Fed.Reg. 33932.

By like token, the Board's rule allows no differentiation for the uniqueness of the many smaller and rural hospitals that constitute approximately one-half of the Michigan Hospital Association's membership. Those smaller and rural hospitals have dramatically different organizational structures and staffing patterns to reflect the lesser size and complexity of the institution. But the Board's rule treats all acute care hospitals as though they are the same — whether they have 8,000 employees or just 80. The rule effectively denies a hospital's right to adduce evidence regarding its own uniqueness or differentiation from the Board's perceived pattern.

As a final matter, the Board's second-guessing of Congress' concern in 1974 about proliferation of units in the health care industry is itself evidence of arbitrariness. The Board suggests in its Final Rule that Congress' articulated fear of work stoppages, jurisdictional disputes, wage whipsawing, and leapfrogging in the health care industry was unfounded because "multiple units have not been shown to cause an unusual number of work stoppages, nor that have they been shown to have caused jurisdictional

disputes, wage whipsawing, or leapfrogging. . . . [T]here were virtually none of the disruptive consequences which concerned Congress during the 1974 debates" (54 Fed.Reg. 16346). The Board's logic misses the point that the courts have not tolerated proliferation of bargaining units in the hospital industry. The courts have rejected the eight units prescribed by the Board in its early decisions. These are the same eight units as those now prescribed in the rule. The evils feared by Congress have not been permitted to occur, as well they might if the Board's rule were now allowed to take effect.

CONCLUSION

The validity or invalidity of the Board's rule should be resolved now, so that much litigation may be avoided. The American Hospital Association's petition for a writ of certiorari should be granted.

Respectfully submitted,

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